Division of Health Care Finance and Policy

Responses to Providers' 835 Questions and Concerns

Strategic Resource Group, Inc (Cambridge Health Alliance, Northeast Health Systems)
June 9th, 2008

Q1. Component/Sub-Element Separator Character (ISA16) same as Data Element Separator.
A1. This was a translation error that had assigned an asterisk as the Component Data Element Separator. This has been rectified and the Component Element Separator reported in ISA16 is a colon (:).

Q2. Interchange Control Version Number (ISA12) is wrong value
A2. ISA12 was reporting 0041 as the value but should be 00401, this typo has been corrected and ISA12 now reports 00401.

Q3. Every Segment has a trailing Element Separator
A3. Due to an element counting error in the application, the system was reporting an additional Element Separator, an asterisk (*), this included trailing Not Used elements as well plus one additional. This has been corrected.

Q4. Segment BPR has too many Element Separators
A4. This was corrected when Q3 was corrected.

Q5. Payer ID Qualifier/Code (1000A/N103, 1000A/N104) not consistent
A5. A request has been submitted to the Developer to align the logic with the WPC specification

Q6. Payer Address Segments (1000A/N3 and 1000A/N4) are missing
A6. Under the Washington Publishing Company 835 Standard the interpretation of this segment was Optional. It is noted that Loop 1000A is required but N3 and N4 are Optional. HSN will add the address of 2 Boylston Street, Boston MA 02116 to this loop and segments aid providers.

Q7. Optional Data Elements that have no values at the end of the segment should be removed
A7. This was corrected when Q3 was corrected.

Q8. Provider Summary Segment (TS3) has invalid Quantity/Amount of Claims
A8. This was corrected to report the correct number of claims within the loop. If it is found that there is a discrepancy please notify the Marc Prettenhofer at Marc.Prettenhofer@state.ma.us.

Q9. Optional Quantity/Amount Fields should not contain 0; they should be nil
A9. This was corrected when Q3 was corrected for most fields. The CLP and CAS segments will be programmed so that dynamic exclusion of a null set will occur with the value equals zero.

Q10. Amounts should not contain trailing cents when 0
A10. A request has been submitted to the developer to remove all trailing zero cents on the file. Includes trailing single digit zeros as well.

Q11. Patient ID (2100/NM109) is missing
A11. This element was being used differently by various providers. Where HSN expected to have either a MassHealth RID, an SSN or ITIN, or the Dummy Default of 000000001, providers were putting PHI in this particular field (HCPCS, CPTS, Diagnosis Descriptions, etc) or types of 'reminder' notes for billing

and collections. Regardless of what the provider sends in the particular element, HSN will now report back only the Dummy Default, to secure information. However, to create a 'triangle' of identifying information for providers, the Medical Record REF segment has now been included in Test. This will be transitioned over to Production by the second week of August.

Q12. Claim Date Segment has wrong date
A12. This element was originally programmed to match the UCP process, which was to use the From Date, this has been corrected and HSN will be using the Through Date.

Q13. Claim Contact Information for Extension is incomplete
A13. There was a possibility for having a direct line for 835 specific questions. Since this was not developed, the Extension qualifier has been removed and all questions currently for the 835 will go directly to Division's Help Desk at 1 800 609 7232.

Q14. Write-Off Amount is missing on Paid/Processed claims
A14. This was a mapping issue in the claims data that has since been resolved. Providers that receive a 0.00 with a Claim Adjustment Reason Code of COA7 should contact Marc Prettenhofer at Marc.Prettenhofer@state.ma.us.

Q15. Claim originally failed on the Validation Report, but shows as a Paid/Processed claim
A15. Claims that have contradictory reporting between the Field Edit Report and the 835 should be noted and sent back to the Division via email for investigation. At this time it appears all codes are mapped appropriately.

Q16. Denied claims include write-off CAS Segment
A16. The occurrence of a denied claim also having a zero (0.00) amount in a CO*B2 (now CO*A7) has been fixed. This was a logic issue that needed to be worked out between two systems.

Q17. Secondary claims are out of balance
A17. Some Secondary claims will be out of balance due to the lack of information received from providers. At this time the HSN 835 is not paying the Secondary Claim, and the actual payment is calculated weeks later and based upon a percentage of Secondary Amount submitted (for non-Medicare primaries). HSN will continue to report Secondaries with just the Total Charges of the claim and reporting back the amount as submitted in the AMT01 = C5 segment. As HSN moves towards full claim adjudication, this will be expanded for additional elements.

Additional questions:
June 12th, 2008
Q18. ISA Sender ID and Receiver ID are reversed
A18. This was an error in the 835 Application that had transposed the ORG IDs, this has been corrected.

Q19. GS Sender ID is wrong
A19. This was corrected with Q18 correction has it was a transposition of the ORG IDs.

Additional questions – Northeast Health Systems:
July 9th, 2008
Q18b. Several accounts in the file were processed with a Claim Status Code (CLP02) of "3", which indicates HSN was 'processed as tertiary' payer. Yet HSN was the only payer on these claims; there was no other prior payer data included.
A18b. This is a mapping issue and has been submitted to the Developer for correction.

Q19b. Several accounts in the file were processed with a Claim Status Code (CLP02) of "17", which indicates HSN "Suspended – Review Pending". Yet these claims have an Adjustment Code CO*A7, which would indicate that these claims were being treated as 'processed/paid'.
A19b. Any account that is coded as HSN Type = Medical Hardship will receive the Claim Status Code of 17 due to the nature of Evidence Collection activity for Inpatient claims. They are still accepted into the system so they also get the code of CO*A7 indicating that they have passed all the other edits, bar one. No claim on the HSN 835 is paid; it is only to indicate that a claim has been accepted into the HSN system for payment consideration. There will be claims that initially processed as Accepted, but upon any Eligibility re-verification will appear on the Monthly Denial list as denied. You should only see "17" on Inpatient Medical Hardship, if this appears on any other HSN Type, notify the Division immediately.

Caritas Christi Group
June 11th, 2008

Q1. No header record – unable to read into Meditech HIS system without a header record.
A1. There are various Header Records that HSN is not using. Provider will need to define which of the missing Header Records is causing a 'load' problem. Send to Marc Prettenhofer at Marc.Prettenhofer@state.ma.us

Q2. Noticed use of inactive HIPAA codes. BC is an inactive code (according to Washington Publishing Company)
A2. COB2 was being used during the Test Phase so that there would be little or no confusion. The code that HSN will be using to indicate that the claim has been processed into the system for Payment Consideration is COA7.

Dana Farber Cancer Institute
June 12th, 2008

Q1. We are not seeing line item (service level) data. All CAS segments are for the claim level only.
A1. HSN is currently only reporting Claim Level data due to the way that the claims are processed for this fiscal year. This will be changed when HSN starts to fully adjudicate the claims.

Q2. Adj Reason Code (ARC) B2 – according to {WPC} is not valid since 10/16/2003
A2. COB2 was being used during the Test Phase so that there would be little or no confusion. The code that HSN will be using to indicate that the claim has been processed into the system for Payment Consideration is COA7.

Q3. In some cases – the same CO*B2 – is used for visits with claims status code (CSC) 4 (denied) and also CSC1 (paid as primary).
A3. Initially COB2 was assigned to all claims to indicate 'acceptance' into the system, however as the system was developed and through discussions with providers at the various Technical Advisory Group Meetings, this was removed due to the dual-use logic which providers' systems could not process.

Q4. Visit CLP*22###61 – is missing the CAS segment
A4. This particular number is not found on the file stated in email. Please verify the file that you are seeing this issue on and report back to Marc Prettenhofer at Marc.Prettenhofer@state.ma.us

Q5. Original 835 file is preformatted (broken in lines/segments with ~ as a line separator). Was it intended?
A5. Yes, the HSN 835 file is segmented and contains a Carriage Return after each segment.

Boston Medical Center
June 30th, 2008

Q1. An ASCII character at the beginning of the ISA segment needed to be removed
A1. HSN is not seeing this ASCII character in any application, nor are all providers receiving this error. From the printout that was received, it may be how your executing program is opening the file. Please review the 835 in another format to verify that the ASCII character is not present.

Q2. The ~ terminator at the end of each segment needed to be removed.
A2. The tilde (~) will be included on the HSN 835 at the end of each segment. If you're specific application does not accept the tilde, this will need to be stripped after being received and before processing.

Q3. The extra * delimiters at the end of each segment needed to be removed
A3. Due to an element counting error in the application, the system was reporting an additional Element Separator, an asterisk (*), this included trailing Not Used elements as well plus one additional. This has been corrected.

S1. Other 835 files that process successfully do not contain characters after the last element in the segment (example provided).
RS1. HSN will be producing the tilde at the end of each segment. Please work with your programmers to remove this character in order to post into your system.

Children's Hospital
July 21st, 2008

Q1. There are invalid characters preceding the ISA segment
A1. HSN is not seeing this ASCII character in any application, nor are all providers receiving this error. From the printout that was received, it may be how your executing program is opening the file. Please review the 835 in another format to verify that the ASCII character is not present.

Q2. There are 2 additional spaces preceding the carriage return at the end of each segment
A2. Change Request submitted to Developer to remove any trailing 'spaces'.

Q3. There were "LQ" segments that should only appear in the SVC (Loop 2110) segments, however since you are not providing line by line service code information, the LQ segments are causing processing issues. Should these remarks appear in the CAS, MOI or MOA segment instead.
A3. The LQ segments provided are necessary when using a 'general' Claims Adjustment Code like CO*96. However, due to the uniqueness of HSN, it was necessary to use LQ segments and Remark Advice Codes so that denial reasons would make sense on a non-payment 835. In cases where this is an issue, you may need to have these separated from the process for manual processing.

Q4. Missing DTM*232* ("From" statement date) for all TCNs

A4. HSN will only be reporting the "Through" dates on the 835 due to Eligibility processing; this will be the DTM segment with DTM01 = 233.

Tufts
July 24th, 2008

S1. The Freecare 835 file contained no payments.
RS1. The HSN 835 is a non-payment 835 as indicated by the BPR01 = I for Remittance Information Only since the detail moved independently from the payment. However, it is now understood where some confusion may arise, since the HSN 835 provides no payment information at all.
BPR segment will be changed to BPR01 = H for Notification Only, that, per the 835 Standard Specification as developed by the Washington Publishing Company for benefit predeterminations. This will remove any indication that a 'payment' should appear on the HSN 835.

Q1. Claims Processes as Primary – no payments, no patient responsibility, bill type – replacement claim, adj code – covered visit, adj amount is the entire billed amount.
A1. As stated above, there will be no payments reported on the HSN 835.
There will rarely be a patient responsibility amount, but in some cases, mostly due to Noncovered Services include with Covered Services, you will see a Patient Responsibility amount equal to the noncovered service amount.
The LX segment reports HSN Claim Type along with the last two digits of the fiscal year that the claims following it were processed as and lastly Bill Type. This matrix will be posted on the HSN website at www.mass.gov/healthsafetynet and navigate to the 835 section for this matrix.

Q2. Claims Denied – three denial reasons.
A2. Provider will need to assist with the concern in the email. Not clear as to what the issue is here. Please submit further information to Marc.Prettenhofer@state.ma.us.

Q3. Claims Processed as Secondary - no payments, no patient responsibility, bill type – replacement claim, adj code – covered visit, adj amount is the entire billed amount.
A3. Answered in A1

Q4. Claims Processed as Tertiary - no payments, no patient responsibility, bill type – replacement claim, adj code – covered visit, adj amount is the entire billed amount.
A4. Answered in A1

Q5. Claims Suspended – review pending – no payments, no patient responsibility, bill type - replacement claim, adj code – covered visit, adj amount is the entire billed amount.
A5. Answered in A1

Q6. Claims Predetermination Pricing Only - no payments, no patient responsibility, bill type - replacement claim, adj code – covered visit, adj amount is the entire billed amount.
A6. Due to the different tiers that providers were at, at the time of creating the 835 Test file, the Predetermination Pricing code was used to push a file out to providers if the data wasn't completely correct coming from the provider. If you see this to continue please inform Marc Prettenhofer at Marc.Prettenhofer@state.ma.us.